Psychiatric Evaluation Form

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Briefly state the reason for this evaluation: _____

_____

_____

_____

Patient's Name:_____Sex: Male/Female (circle one)

Date of Birth:_____Age:_____Patient's Social Security #_____

Address: _____City: _____State: _____Zip Code:_____

Home Phone:_____Cell #:_____Work #_____

Email address: _____

Pharmacy (name, address, telephone) _____

May we leave a message (voice or text)? _____Yes _____No
What phone number may we leave a message? _____Cell _____Home _____Work

LEGAL GUARDIAN INFORMATION (IF NOT THE PATIENT)

Name:_____Relationship to Patient:_____

Address:_____

Home Phone:_____Cell #:_____Work #:_____

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1. Race/Ethnicity (circle one or more):
American Indian/Alaskan Native Asian African-Amer Hispanic Caucasian Other_____

2. Current marital status (check one):
Single Married, living together Separated Widowed Cohabiting w/partner Divorced Married, living apart

3. If you are married or cohabitating with a partner, how long has this been? _____

4. Total number of marriages: _____ 5. How many children do you have? Ages?_____

6. Spouse's/Partner's Name: _____

7. Who else lives with you? _____

8. How many years of formal education have you completed? _____

9. Highest Degree Obtained (circle one):
High School grad GED Junior college degree or technical school 4-year college degree
M.B.A./M.A./M.S./M.P.H. M.D. J.D. Ph.D Other_____

10. Employer Name: _____ 11. Occupation: _____

12. Employment Status (full/part-time, retired, on disability, etc): _____

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Are you currently seeing a therapist or psychiatrist? (Name/contact#) _____

Have you ever seen a psychiatrist/psychotherapist before? If yes, please list: _____

Previous history: Have you ever been treated for any of the following (check all that apply):

_____Depression _____ADHD _____Bipolar (Manic / Depressive) Disorder
_____Anxiety _____OCD _____Schizophrenia
____ Panic Attacks _____PTSD _____Alcohol Problems (including AA)
____Anorexia/ Bulimia _____Binge-eating ____Drug Problems _____ECT treatment

Please list in chronological order all prior psychiatric hospitalizations (if any) below. Use back of this paper or additional sheet if necessary. Please also indicate the reason for each hospitalization.

Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

Have you ever attempted to harm/kill yourself? Circle YES/NO
If yes, please list the occurrences below:

Approximate date of attempt	How did you attempt (method)?

Please List a// current medications below(include birth control pills, over the counter medication and herbal remedies (i.e. decon;Jestants, St. John's Wort etc)

Name of Medication	Dosage(Mg)	How many times a day?	On this for how lona?	Side effects (if any)	Prescribing physician

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Please review the following list of medications. If you have taken any of these medications please fill out the specific boxes related to that medication.

Brand Name	Generic Name	√ if	How long did you take it?	What Dosage did you take? Mg/d	Did it help? √ if yes	How often In a day? Write **1, 2** or **3** times a day	Any Side effects
Selective Serotonin Reuptake Inhibitors(SSRIs)							
Luvox	Fluvoxamine						
Paxil	Paroxetine						
Paxil CR	Paroxetine						
Celexa	Citalopram						
Lexapro	Escitalopram						
Zoloft	Sertaline						
Prozac	Fluoxetine						
Serotonin-Norepinephrine Reuptake Inhibitors,(SNRIs)							
Effexor	Venlafaxine						
EffexorXR	Venlafaxine						
Pristiq	desvenlafaxin						
Cymbalta	Duloxetine						
Other Antidepressants							
Desyrel	Trazadone						
Serzone	Nefazodine						
Wellbutrin XL /SR	Bupropion XL/SR						
Remeron	Mirtazapine						
Viibryd	vilazodone						
Tricyclic Antidepressants							
Adapin	Doxepin						
Anafranil	Clomipramine						
Asendin	Amoxapine						
Elavil	Amitriptyline						
Ludiomil	Maprotiline						
Norpramin	Desipramine						
Pamelor	Nortriptyline						
Sinequan	Doxepin						
Surmontil	Trimipramine						
Tofranil	Imipramine						
Vivactil	Protriptyline						
Other Psychotropics (Have you taken any of these?)							
Ability	Buprenorphin	Dexedrine	Ambien	Klonopin	Emsam	Provigil	Thorazine
Risperidal	Campral	Adderall	Buspar	Ativan	Nardil	Depakote	Dalmane
Invega	Antabuse	Vyvanse	Restoril	Xanax	Parnate	Lithium	Orap
Geodon	Suboxone	Strattera	Sonata	hydroxyzine	Halcion	Lamictal	Navane
Zyprexa	Naltrexone	Concerta	Buspar	Valium	Niravam	Phentermine	Trilafon
Seroquel	Ambien CR	Dexedrine	Halcion	vistaril	Tranxene	Tegretol	Mobane
Symbyax	Valproic Acid	Focalin	Atarax	Methadone	Cylert	Topamax	Stelazine
Clozapine	Adderall XR	Ritalin	Librium	Synthoid	Viibryd	Mellaril	Haldol
Rozerem	Metadate	Daytrana	Lunesta	Meridia	Saphris	Loxitane	Prolixin

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Family History :Has anyone in your family ever been treated for any of the following (please check all that apply and when appropriate indicate paternal or maternal)

	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparent
Depression								
Anxiety								
Panic Attacks								
Post traumatic stress								
Bipolar/Manicdepression								
Schizophrenia								
Alcohol Problems								
Drug problems								
ADHD								
Suicide attempts								
Psychiatric hospital stay								

Medical History: Do you have, or have you ever had any of the following (please check all that apply)? **Please write in your medical problem in each category**

	Mark✓		Mark✓		Mark✓
High Blood Pressure		Gastrointestinal Problems (ulcers, pancreatits, irritable bowel, colitis)		Viral Illness (herpes, Epstein-Barr, chronic hepatitis)	
Lung Disease		Arthritis or Rheumatoid Problems		Cancer	
Diabetes		Liver Damage or Hepatitis		Genital Problems	
Heart Disease		Other Endocrine/Hormone Problems		Eating Disorder	
Thyroid Disease		Neurological Problems (stroke, brain tumor, nerve damage)		Eye Problems	
Anemia		Gynecological / hysterectomy		Chronic pain	
Asthma		Urinary Tract or Kidney Problems		Fibromyalgia	
Skin Disease		Migraine or Cluster Headaches		HIV Positive or AIDS	
Seizures		Ear/Nose/Throat Problems		Head Injury	
Other medical issues		High Cholesterol		Sleep apnea	

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Regarding alcohol, when was your last drink?_____

In the past 30 days, about how many of those days have you had at least one alcoholic drink? _____

What is the maximum number of drinks you have had in one day in the past month?_____drinks

DUI_____DWI_____Public Intoxication_____Seizures_____DT's_____

Please check the appropriate boxes that apply to you for *abuse* of the following substances:

	Never Used	Age first used	Last used on this approx date	Age peak use	History of abuse?	Current use and frequency
Cocaine						
Amphetamine Or Speed						
Marijuana						
Diet Pills						
Hallucinogens (LSD,mushrooms, Mescaline)						
Ecstasy						
Diuretics						
Tranquilizers						
Pain Pills						
Inhalants						
Sleeping Pills						
Laxatives						
Cigarettes,cigars, Or tobacco						
PCP or Angel Dust						
IV Drug use						
Heroin						
GHB						
Anabolic Steroids						
Caffeine(coffee, Tea,cola's,iced tea						
Benzodiazepines (xanax,valium,ativan Restoril, Librium)						
Other:						

List all prior surgeries and hospitalizations for medical illnesses

_____

_____

_____

Are you allergic to any medication or food? If so, please list below

_____

_____

Last menstrual period (if applicable) _____

Contraceptive method: _____